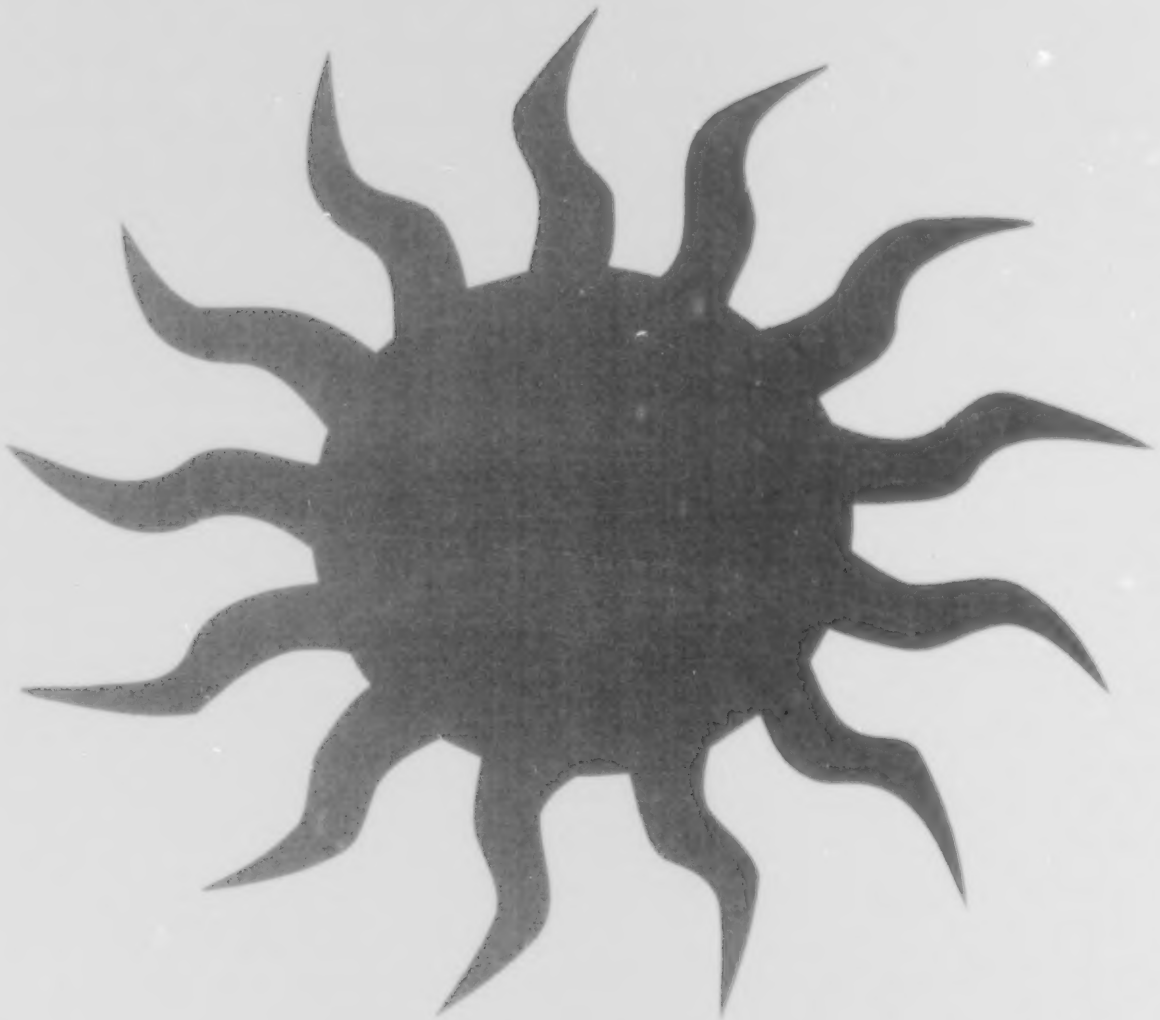
Saskatchewan Health

Healthy People.
A Healthy Province.

Methadone Assisted Recovery Guidelines

For Saskatchewan Addiction Counsellors



March 2004

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ACKNOWLEDGEMENTS

Saskatchewan Health has supported the development of guidelines for physicians prescribing and pharmacists dispensing methadone for opioid dependency that are evidence-based, multi-disciplinary, uniform, and community-based. It became apparent that a need existed to update methadone assisted recovery guidelines for addictions counsellors throughout the province to provide new research information on methadone assisted recovery, as well as to provide a set of guidelines for addiction counsellors working in methadone assisted recovery.

A subcommittee of the Provincial Alcohol and Drug Services Working Group was struck to develop these guidelines in 2002. Representation on the subcommittee included addiction counsellors working with individuals in methadone assisted recovery, addiction counsellors unfamiliar with methadone assisted recovery, and other stakeholders. The subcommittee sincerely hopes that these guidelines will be a useful tool for both experienced and new addiction counsellors involved in methadone assisted recovery.

Subcommittee members included:

- Chair: Sharon Erickson, Five Hills Health Region, Addiction Services
- Brenda Senger, Saskatoon Health Region, Addiction Services
- Brenda Cameron, Saskatoon Health Region, Addiction Services
- Don Balfour, Regina Qu'Appelle Health Region, Addiction Services
- Chuck McCann, Saskatoon Health Region, Addiction Services
- Gerri Madill, Saskatoon Health Region, Provincial Program Support Unit
- Dr. Lowell Loewen, College of Physicians and Surgeons of Saskatchewan
- Kirsty Carlson, Mayfair Drugs, for the Saskatchewan Pharmaceutical Association
- Garth King, Saskatchewan Department of Corrections & Public Safety
- James Froh, Saskatchewan Health, Community Care & Population Health Branches

Focus groups were conducted in Prince Albert, Regina, and Saskatoon during February and March of 2003 with clients in methadone assisted recovery. Participation was voluntary and individual opinions are recorded in Appendix I.

These guidelines, together with physician and pharmacist guidelines, provide provincial expectations and recommendations for methadone assisted recovery services in Saskatchewan.

EXECUTIVE SUMMARY

INTRODUCTION

These provincial guidelines describe the role, services, and skills required of the addiction counsellor, depending on her/his level of involvement with individuals in Saskatchewan who have been prescribed methadone for opioid dependency. Methadone is a prescription drug used to safely treat opioid addiction for over forty years. Furthermore, methadone assisted recovery can be an important harm reduction strategy to prevent the transmission of HIV and other blood-borne pathogens, while assisting those using opioids to reduce illicit use, needle sharing and criminal activity associated with opioid use.

Addiction counsellors can be involved in several key areas of methadone assisted recovery, such as the initial referral, screening, problem severity assessment, direct interventions with the individual, interventions on behalf of the individual, case management, and evaluation/outcome assessments. The counsellors' involvement with opioid dependent clients address all the usual complex dependency issues, such as drug use, physical, mental, social, and legal health concerns, plus the potential involvement of one or more therapeutic drugs. Addiction counsellors have a vital role in providing relapse prevention education and counselling to clients on methadone. Specific skills are required, depending on each addiction counsellor's level of involvement in the methadone assisted recovery process.

EFFECTS OF OPIOIDS

Opioids briefly stimulate the higher centres of the brain but then depress activity of the central nervous system. Opioids reduce anxiety and pain, and produce euphoria and a sense of well-being. Short-term effects appear soon after a single dose and disappear in a few hours. Immediately after injecting an opioid, the individual feels a surge of pleasure or a "rush". Hunger, pain, and sexual urges rarely intrude following opioid injection. The dose required to produce this effect may at first cause restlessness, nausea, and vomiting.

Opioid overdose is a particular risk with illicit use where the actual substance and strength may not be accurately known. Signs of opioid overdose include: the individual cannot be roused; pupils contract to pinpoints; skin is cold, moist, and bluish; and profound respiratory depression. For the opioid-dependent individual, opioid withdrawal symptoms may occur within a few hours after the last dose of opioids. During withdrawal, the individual experiences the exact opposite of the drug effects of opioids, including increased anxiety, pain, uneasiness and agitation. Opioid withdrawal is generally less dangerous than alcohol, barbiturate, and benzodiazepine withdrawal.

PHARMACOLOGY OF METHADONE

Methadone is a synthetic opioid with actions similar to those of morphine. Methadone has three important functions: relief of pain for about 6 hours; suppression of opioid withdrawal and craving for about 24 hours; and a mood stabilizing effect for longer periods. Clients should discuss all drug use and prescription drug use with their methadone prescribing physician and/or their pharmacist(s).

When an individual is stabilized on methadone, the administration of a single adequate dose (usually between 60 to 120 mg) will suppress withdrawal and craving for about 24 hours without causing euphoria or sedation. Individuals can therefore function normally and are able to perform mental and physical tasks without impairment. In sufficient doses, methadone "blocks" the euphoric effects of other opioids.

METHADONE TREATMENT OVERVIEW

Methadone treatment goals include: reducing harms of drug use; treating medical and psychiatric co-morbidity; bringing substance dependence into remission; and achieving the highest possible level of psycho-social function. In collaboration with clients, addiction service counsellors and pharmacists, methadone-prescribing physicians direct methadone treatment in Saskatchewan. Please see the attached Methadone Treatment Overview illustration.

Abstinence-based alcohol and drug treatment is only effective for a small number of opioid dependent individuals. Research suggests that for opioid-dependent individuals, counselling alone is not effective because the withdrawal and cravings are so intense. Methadone alone may work if prescribed in sufficient doses to control withdrawal and craving. Methadone plus skilled counselling has better outcomes than methadone alone.

METHADONE ASSISTED RECOVERY

In these guidelines, methadone assisted recovery refers to the care and treatment of all individuals prescribed methadone for opioid dependency. Research suggests that it takes two or more years to go through methadone treatment phases and arrive at one of three outcomes: long-term methadone maintenance; medically supervised withdrawal from methadone; or methadone harm reduction. During methadone assisted recovery, there may be considerable overlap and cycling between the three outcomes. The five phases of methadone treatment may be described as: 1) Initiation, 2) Stabilization, 3) Determination, 4) Action, and 5) Maintenance.

SCREENING PROCESS

The Screening Process is the first step in the motivational assessment process that is to be completed by a trained addiction counsellor. The complete process involves screening, problem severity assessment, assessment feedback, and recovery planning. If the screening suggests that the individual is opioid dependent, the addiction counsellor will refer the client to a methadone-prescribing physician with accompanying rationale and recommendations. Other options include referring the individual to community-based treatment services such as detoxification, outpatient, or inpatient treatment. Please see the attached Screening Process illustration.

PROBLEM SEVERITY ASSESSMENT

It is recommended that the addiction counsellor continue with the second step of the motivational assessment process, the Problem Severity Assessment, only when an individual is sufficiently stabilized on prescribed methadone to meaningfully engage in the motivational assessment process. The Problem Severity Assessment has two purposes: to collect information about the effect of alcohol or drug use on the individual's life; and to identify strengths that can provide a foundation for recovery. Please see the attached Problem Severity Assessment illustration.

SASKATCHEWAN MODEL OF RECOVERY SERVICES

Methadone assisted recovery supports Clinical Principle 3 in the Saskatchewan Model of Recovery Services. It defines recovery as establishing/re-establishing: patterns of healthy living; growth process; active process; comprehensive process; and individualized process. Clinical Principle 4 further defines the

recovery from dependency as a developmental growth process, with specific stages and tasks, which must be completed before moving on to the next recovery stage. The six stages are: 1) transition, 2) stabilization, 3) early recovery, 4) middle recovery, 5) late recovery, and 6) maintainance.

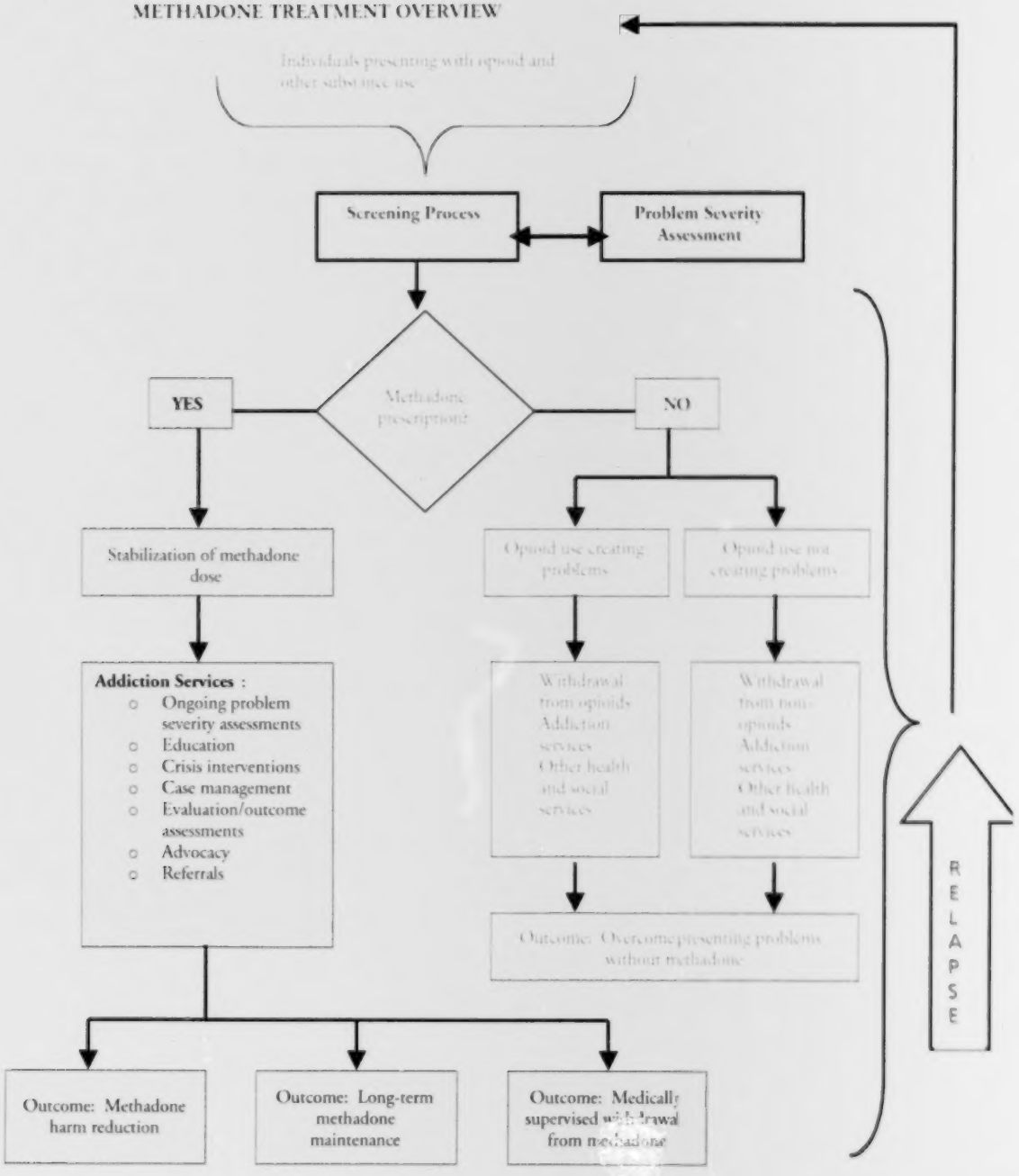
OTHER ISSUES RELATED TO METHADONE ASSISTED RECOVERY

Evidence based counselling practices are recommended as the basis for methadone counsellor/client interactions. Special consideration should be given to case management of situations and circumstances such as: transfers to other methadone-prescribing physicians; methadone & pregnancy; concurrent disorders; adolescent clients; and offenders in custody.

CO-MANAGEMENT OF RECORD KEEPING IN METHADONE TREATMENT

Good communication among physicians, addiction counsellors, pharmacists, and other healthcare providers is essential to protect the privacy and confidentiality of health information in the co-management of individuals prescribed methadone for opioid dependency. The addiction counsellor will comply with federal and provincial regulatory requirements. The sharing of information between addiction counsellors and physicians, and vice-versa, requires a signed client consent form authorizing communication and release of information. The information that is to be shared shall be on a need to know basis and applicable to the medical management and treatment of the client.

METHADONE TREATMENT OVERVIEW



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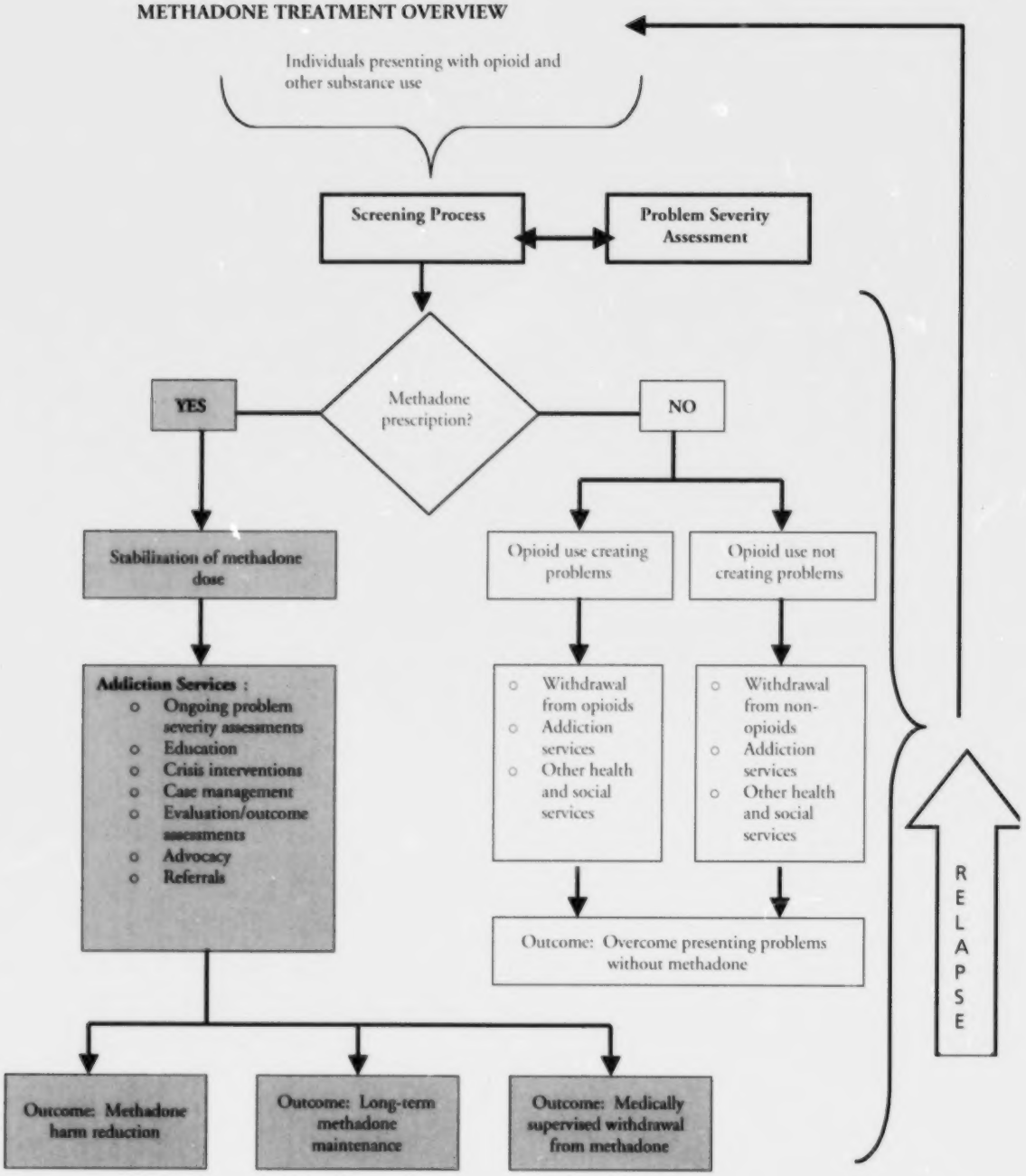

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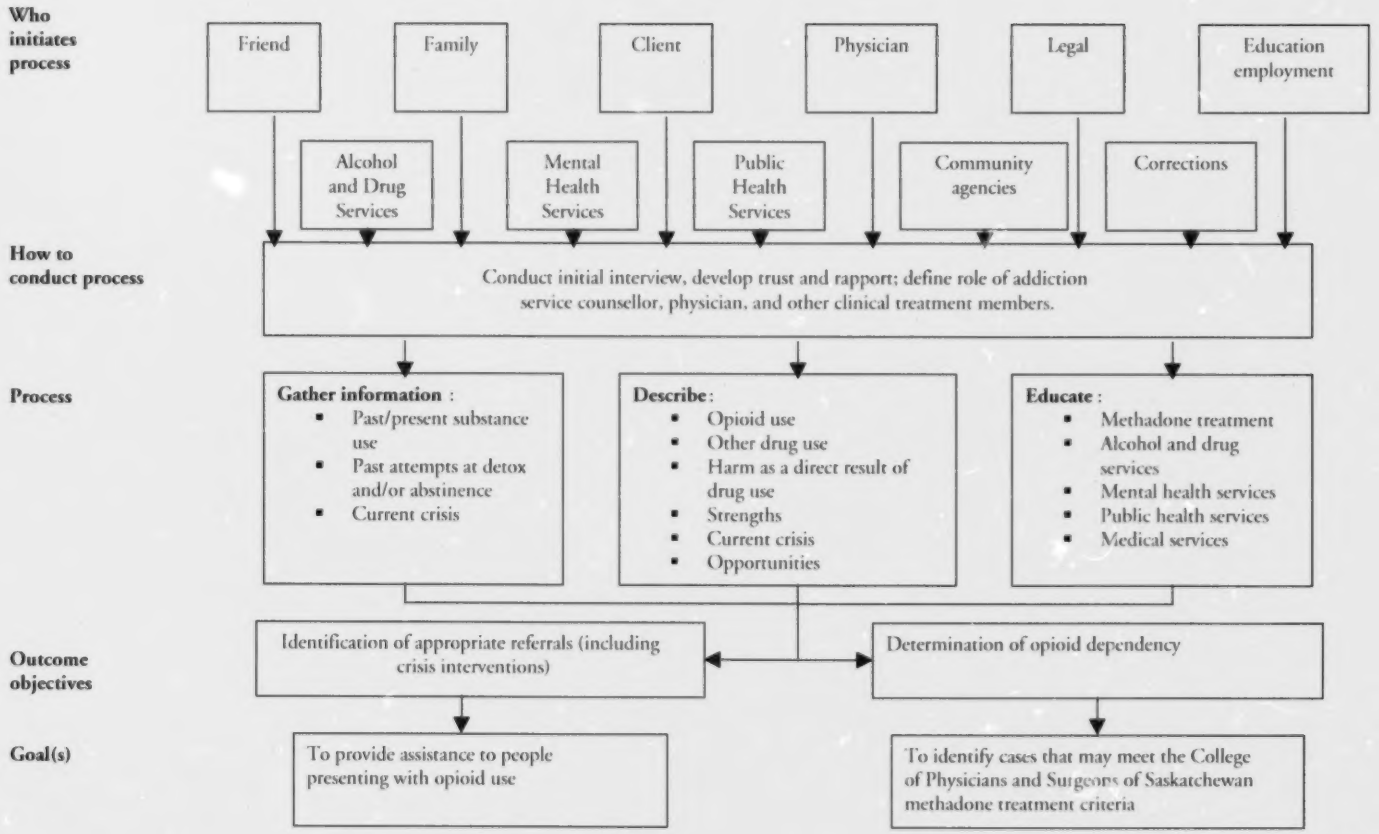

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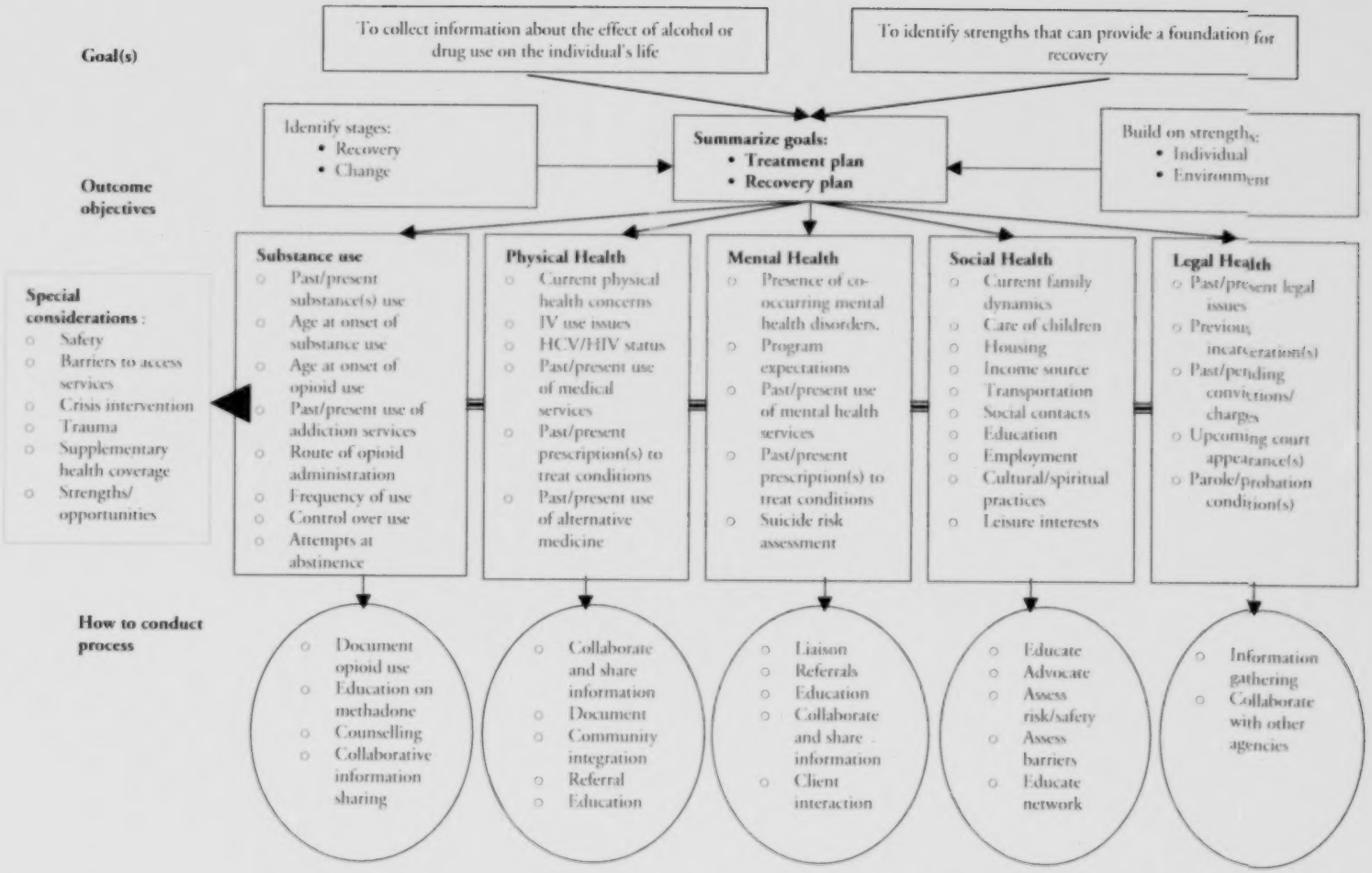

1. INTRODUCTION

These provincial guidelines describe the role, services, and skills required of the addiction counsellor, dependi g on her/his level of involvement with individuals prescribed methadone for opioid dependency in Saskatchewan. For more information on addiction and opiates please see **Appendix A**.

Methadone is a prescription drug used to safely treat opioid addiction for over forty years (Ball & Ross, 1991; Farrell et al., 1994). Methadone has been used since the 1970s as a significant option for opioid dependant individuals in Saskatchewan. For information on the pharmacology of methadone provided by the Saskatchewan Pharmaceutical Association, please see the corresponding section of these guidelines.

The number of people prescribed methadone in Canada has risen significantly in recent years. In Saskatchewan, there were less than 200 methadone clients in 1997, and more than 1,300 in 2003. This increase reflects current public health policies that have been changed in recent years in an effort to reduce illicit drug use. Saskatchewan Health has encouraged the development of guidelines and the adoption of best practices to support the delivery of uniform, community-based, and comprehensive methadone assisted recovery services in Saskatchewan.

Methadone assisted recovery can be an important harm reduction strategy to prevent the transmission of HIV and other blood-borne pathogens. Furthermore, this form of treatment has potential to assist those using opioids to reduce illicit use, needle sharing, and criminal activity associated with opioid use.

Provincial physician guidelines for the treatment of opioid dependency (College of Physicians and Surgeons of Saskatchewan, 2002) support physicians prescribing methadone in Saskatchewan. Provincial pharmacist guidelines (Erickson, Postnikoff, Rhode, & Wurtz, 2001) assist pharmacists dispensing methadone in the province.

Opioid dependency, and addiction generally, is a complex process involving many biological, psychological, social and spiritual factors. Opioid dependent clients have a high frequency of psychiatric co-morbidity. Many individuals may lack necessary coping strategies and other life skills that allow them to function successfully.

There is strong evidence to support improved outcomes when methadone treatment for opioid dependence includes addiction counselling (Farrell et al., 1994; Millar, 1998; Moolchan &

In 1995, methadone was comprehensively re-evaluated by the National Institute on Drug Abuse in the United States and found to be effective for opioid addiction. Researchers found that methadone in adequate dosage and with supportive therapy:

- **reduces illicit opioid use**
- **reduces criminal activity**
- **improves social health and productivity**
- **improves physical health**
- **reduces HIV transmission**
- **improves pregnancy outcomes in opioid addicted women**
- **is safe for long-term use**

Some of the client focus group comments are included throughout these guidelines. For a complete record of these comments please see Appendix I.

"Identify the problems right away and get working on them, that is why you are an addict e.g. past abuse – there are underlying reasons for using street drugs and these must be identified in order to overcome addiction – after being involved with the program for a while I was encouraged to deal with my problems."

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Hoffman, 1994; Roberts et al., 1999). Methadone assisted recovery enables the individual to make signficant changes, facilitates return of function, and complements the goals of traditional alcohol and drug recovery.

Addiction counsellors can be involved in several key areas of methadone assisted recovery, such as the initial referral, screening, problem severity assessment, direct interventions with the individual, interventions on behalf of the individual, case management, and evaluation/outcome assessments.

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In particular, addiction counsellors need to be knowledgeable about:

- Substance use and dependency
- Opioid dependency in particular
- Physical, mental, social health as well as legal aspects of opioid dependency
- Use of methadone in care and treatment of opioid dependency
- Methadone treatment processes and outcomes

A Health Canada literature review (Brands, Marsh, Hart & Jamieson, 2002) indicates that methadone treatment is effective in reducing:

- **opioid use**
- **stimulant use, e.g. cocaine**
- **injection drug use and related risk behaviours, e.g. needle sharing**
- **criminal activity**
- **opioid overdose**
- **other risk behaviours for transmission of HIV and STDs, e.g. unprotected sex**

Methadone assisted recovery has also been found to improve:

- **general health**
- **social functioning**
- **self esteem**
- **family relationships**
- **ability to parent**
- **pregnancy outcomes**
- **access to counselling**
- **money management**
- **employment**

Roles in methadone treatment

Physician

- Medical assessments
- Diagnosis
- Prescribing take-home methadone (carries)
- Referrals for physical and mental health assessments

Pharmacist

- Dispensing methadone
- Brief encounters
- Observation
- Education

Addiction Counsellor

- Motivational assessment process
- Education
- Intervention/referrals in social and legal matters
- Case management
- Evaluation/outcome assessments

2. EFFECTS OF OPIOIDS

Opioids briefly stimulate the higher centres of the brain but then depress activity of the central nervous system. Opioids reduce anxiety and pain, and produce euphoria and a sense of well-being. Short-term effects appear soon after a single dose and disappear in a few hours. Immediately after injecting an opioid, the individual feels a surge of pleasure or a "rush". Hunger, pain, and sexual urges rarely intrude following opioid injection. The dose required to produce this effect may at first cause restlessness, nausea, and vomiting.

The effect of opioids, as with other drugs, is dependent on several factors:

- Amount taken
- Frequency of use
- Other substance use
- Past drug experience
- Route of administration
- Environment/circumstances in which drugs are taken

With **moderately high doses** the individual goes on *the nod*, an alternately wakeful and drowsy state during which:

- Body feels warm,
- Extremities feel heavy
- Mouth feels dry
- Breathing becomes gradually slower
- World is forgotten

Opioid overdose is a particular risk with illicit use where the actual substance and strength may not be accurately known. Signs of opioid overdose include:

- Individual cannot be roused
- Pupils contract to pinpoints
- Skin is cold, moist, and bluish
- Profound respiratory depression

For the opioid-dependent individual, opioid withdrawal symptoms may occur within a few hours after the last dose of opioids. During withdrawal, the individual experiences the exact opposite of the drug effects of opioids, including increased anxiety, pain, uneasiness and agitation. Opioid withdrawal is generally less dangerous than alcohol, barbiturate, and benzodiazepine withdrawal.

Opioid withdrawal management can be found in the *Withdrawal Management Protocols* produced in 2001 by Saskatchewan Health, the College of Physicians and Surgeons and the Saskatchewan Medical Association.

Acute opioid withdrawal symptoms result if use of the drug is reduced or stopped abruptly and usually peak about 72 hours after the last dose and subside after a week. Bodily functions, such as sleep patterns, bowel disturbance, and sexual dysfunction may not return to normal levels for as long as six months.

Acute opioid withdrawal symptoms include:

- Tearing
- Sweating
- Runny nose
- Uneasiness
- Craving for the drug
- Dilated pupils
- Loss of appetite
- Goose pimples
- Irritability
- Tremor
- Bone, joint pain
- Severe insomnia
- Violent yawning
- Weakness
- Nausea, vomiting, diarrhea
- Chills, fever
- Muscle spasms
- Abdominal pain

"I got too concerned with getting off meth and set myself up for a relapse"

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- Weakness
- Nausea, vomiting, diarrhea
- Chills, fever
- Muscle spasms
- Abdominal pain

"I got too concerned with getting off meth and set myself up for a relapse"

3. PHARMACOLOGY OF METHADONE

Methadone is chemically unrelated to opiates. It is a synthetic opioid with actions similar to those of morphine. When necessary, opiates can be prescribed along with methadone to treat chronic or post-operative pain.

Methadone has three important functions:

- Relief of pain for about 6 hours
- Suppression of opioid withdrawal and craving for about 24 hours
- A mood stabilizing effect for longer periods

Mainly the liver metabolizes methadone. A very small percentage of individuals metabolize methadone rapidly (for example, pregnant women and those involved in intense physical activity) and they can experience withdrawal even on a relatively high methadone dose. Split doses may be necessary for these individuals.

Clients should discuss all drug use and prescription drug use with their methadone prescribing physician and/or their pharmacists. Certain drugs can increase the effects of methadone.

Prescribed methadone is used in treating opioid dependency in methadone assisted recovery. It involves the daily administration of methadone over an extended time period. Methadone is only dispensed from a pharmacy as an oral drink in a flavoured juice such as orange 'Tang'. Methadone is absorbed in the gut within 45 minutes and its effect usually peaks within 2-3 hours after drinking the medication.

When an individual is stabilized on methadone, the administration of a single adequate dose (usually between 60 to 120 mg) will suppress withdrawal and craving for about 24 hours without causing euphoria or sedation (Farrell et al., 1994; Roberts et al., 1999). Individuals can therefore function normally and are able to perform mental and physical tasks without impairment. In sufficient doses, methadone "blocks" the euphoric effects of other opioids.

Side effects of methadone can vary, depending on the individual. An increase in methadone dosage may cause drowsiness for 3 days, making driving and other activities requiring alertness hazardous.

If methadone is abruptly discontinued, abstinence syndrome may develop with many of the symptoms previously described for opioid withdrawal.

"Difficult withdrawal (pain) leads you back to using even though you really want to get clean."

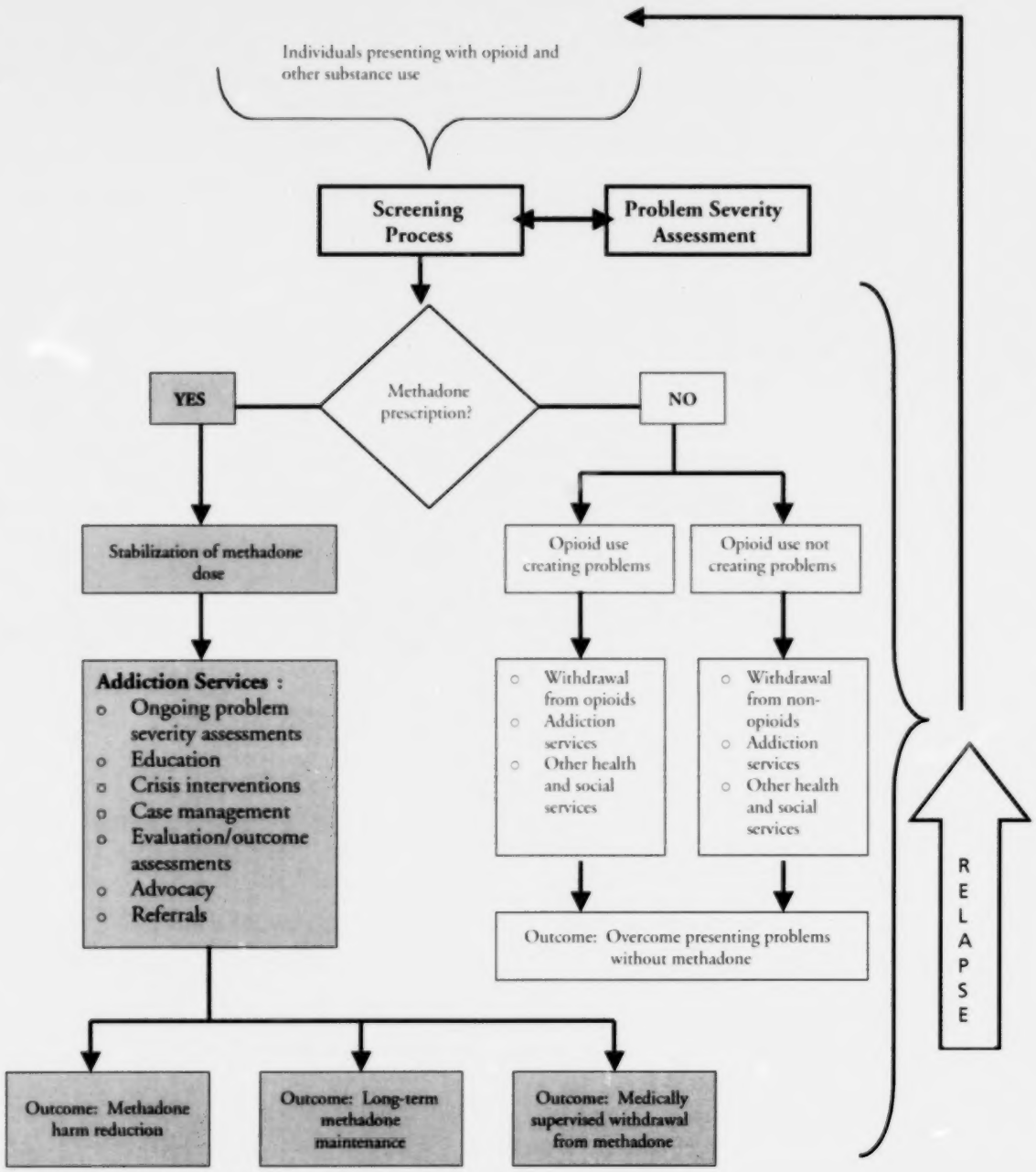
"Meth was the only thing that stopped me from using. I had only gone 2 days on my own, was shoving needles from age 18 to 31 and now I'm 33."

"I now have 5 years of not using."

Methadone can be dangerous if misused. The real dangers of respiratory failure and death exist with doses greater than 30 mg for individuals not accustomed to methadone. A dose of as little as 10 mg can be fatal to a child.

"The first 3 - 4 days you need transportation until stable – should be provided rides, even when walking home you are throwing up and drowsy – at first you feel so bad you do not even want to get out of bed and walk in the winter or take your kids with you."

4. METHADONE TREATMENT OVERVIEW



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- A mood stabilizing effect for longer periods

Mainly the liver metabolizes methadone. A very small percentage of individuals metabolize methadone rapidly (for example, pregnant women and those involved in intense physical activity) and they can experience withdrawal even on a relatively high methadone dose. Split doses may be necessary for these individuals.

Clients should discuss all drug use and prescription drug use with their methadone prescribing physician and/or their pharmacists. Certain drugs can increase the effects of methadone.

Prescribed methadone is used in treating opioid dependency in methadone assisted recovery. It involves the daily administration of methadone over an extended time period. Methadone is only dispensed from a pharmacy as an oral drink in a flavoured juice such as orange 'Tang'. Methadone is absorbed in the gut within 45 minutes and its effect usually peaks within 2-3 hours after drinking the medication.

When an individual is stabilized on methadone, the administration of a single adequate dose (usually between 60 to 120 mg) will suppress withdrawal and craving for about 24 hours without causing euphoria or sedation (Farrell et al., 1994; Roberts et al., 1999). Individuals can therefore function normally and are able to perform mental and physical tasks without impairment. In sufficient doses, methadone "blocks" the euphoric effects of other opioids.

Side effects of methadone can vary, depending on the individual. An increase in methadone dosage may cause drowsiness for 3 days, making driving and other activities requiring alertness hazardous.

If methadone is abruptly discontinued, abstinence syndrome may develop with many of the symptoms previously described for opioid withdrawal.

"Difficult withdrawal (pain) leads you back to using even though you really want to get clean."

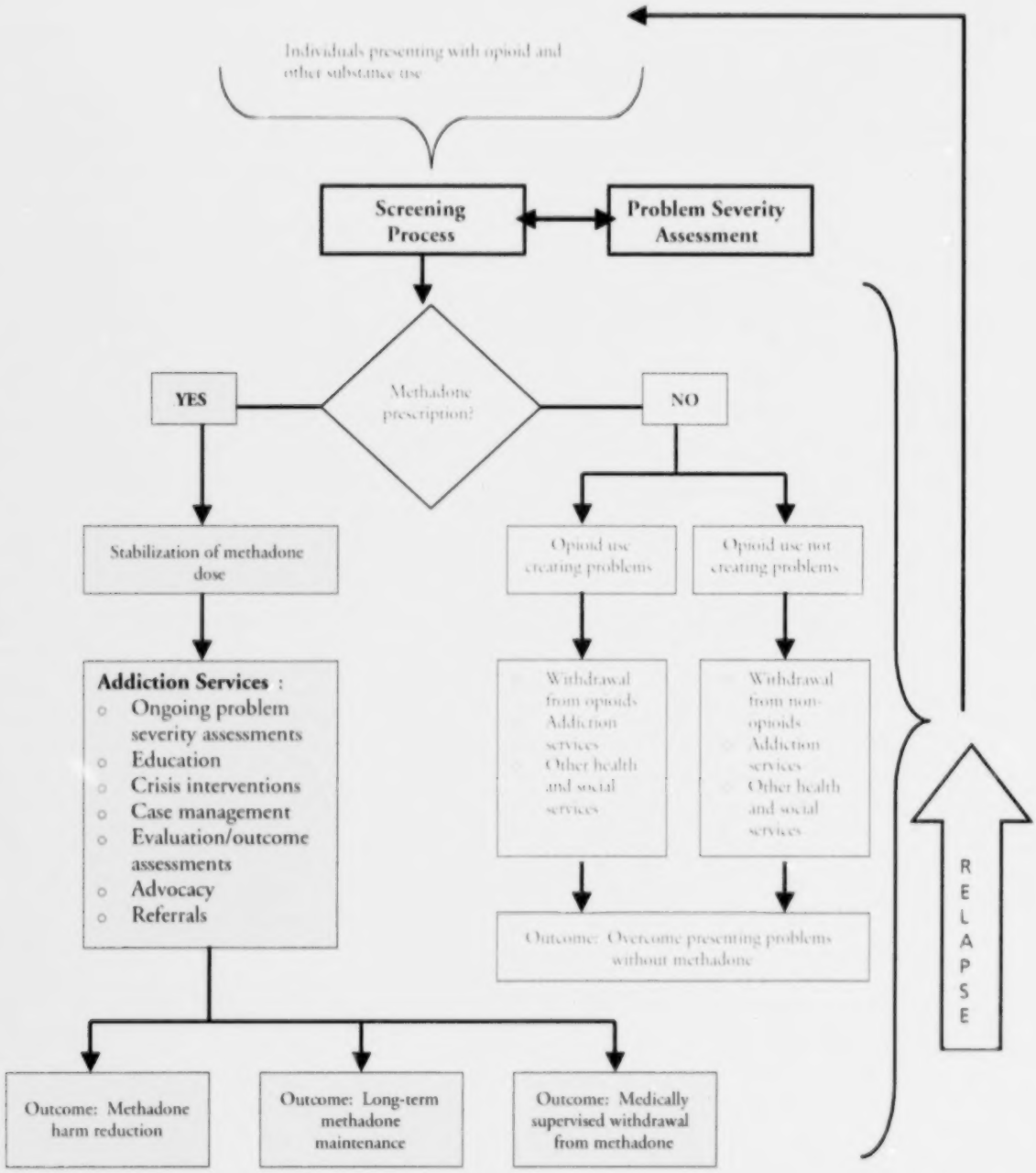
"Meth was the only thing that stopped me from using. I had only gone 2 days on my own, was shoving needles from age 18 to 31 and now I'm 33."

"I now have 5 years of not using."

Methadone can be dangerous if misused. The real dangers of respiratory failure and death exist with doses greater than 30 mg for individuals not accustomed to methadone. A dose of as little as 10 mg can be fatal to a child.

"The first 3 - 4 days you need transportation until stable – should be provided rides, even when walking home you are throwing up and drowsy – at first you feel so bad you do not even want to get out of bed and walk in the winter or take your kids with you."

4. METHADONE TREATMENT OVERVIEW



Methadone treatment goals:

- reduce harms of drug use
- treat medical and psychiatric co-morbidity
- bring substance dependence into remission
- achieve the highest possible level of psycho-social function

Methadone treatment for opioid dependence is delivered in methadone clinics, family medical clinics, and correctional institutions in Saskatchewan. In collaboration with clients, addiction service counsellors, and pharmacists, methadone-prescribing physicians direct methadone treatment in Saskatchewan. All healthcare providers promote the normalization of client lifestyles and behaviour patterns in methadone treatment.

Abstinence-based alcohol and drug treatment is only effective for a small number of opioid dependent individuals. Research suggests that for opioid-dependent individuals, counselling alone is not effective because the withdrawal and cravings are so intense (Ward, Mattick & Hall, 1998). Methadone alone may work if prescribed in sufficient doses to control withdrawal and craving. Methadone plus skilled counselling has better outcomes than methadone alone (Farrell et al., 1994; Millar, 1998; Moolchan & Hoffman, 1994; Roberts et al., 1999).

Addiction counsellors may provide referral, screening, problem severity assessment, and orientation services to individuals presenting with opioid and other substance use. Once individuals are prescribed methadone for opioid dependency, addiction counsellors may also provide ongoing problem severity assessment, interventions/referrals, case management, advocacy and evaluation/outcome assessment services.

Upon **intake**, addiction counsellors share information from screening interviews and problem severity assessments (described in Section 6 & Section 7) with methadone-prescribing physicians.

A methadone-prescribing physician conducts initial consultations during intake to determine whether each individual meets the College of Physicians and Surgeons of Saskatchewan methadone treatment admission criteria **(Appendix B)**. **Based on all available information, the physician makes the decision to prescribe methadone and/or to refer the individual to other health care services**. Before prescribing methadone, the physician must ensure the individual signs a treatment agreement.

Options for treating opioid dependence in Saskatchewan include:

- **Withdrawal from opioids without methadone.**
- **Long-term methadone maintenance** for those with high function and no significant substance use.
- **Medically supervised withdrawal from methadone** for those who can overcome opioid dependency.
- **Methadone harm reduction** for those where reducing harm is the best the individual can do.

"Counsellors should be educated, not ignorant (about drug use etc.) be accessible, provide information sessions for everybody (clients and other professionals – mayor, police, justice system)."

"Need counsellors, need a place to spill your guts, stigma in other places and you gotta talk."

"Yes, need counsellors for things that you need, for guidance, learn to get back on your feet, able to get into university classes."

Information on methadone treatment for opioid dependency in Saskatchewan (the what, where, why, who, when, how, and how much) is routinely provided to clients and the general public by addiction counsellors, pharmacists, and physicians. Information is to be communicated in a respectful way using simple concepts and language.[1] In addition, addiction counsellors have a responsibility to educate the public on the benefits and risks of methadone treatment.

During **orientation** of new clients, the addiction counsellor seeks to:

- Provide information about healthcare providers involved in methadone treatment
- Outline addiction counsellor services
- Outline client responsibilities
- Address client expectations, questions and concerns
- Educate clients to clinic staff, community pharmacists, and other community service providers
- Inform clients of other available services delivered through methadone-prescribing physician offices, methadone clinics, participating community pharmacies and alcohol and drug services.

Two client orientation handouts are found in Appendix C & Appendix D. They answer the following questions.

- **What is Methadone and how is it used?**
- **What is the long-term goal of methadone treatment?**
- **Is methadone safe?**
- **How much methadone does a person need?**
- **Are there adverse effects?**
- **How long will treatment take?**
- **What will it cost?**
- **Benefits & risks of Methadone treatment**
- **What are some of the rules of the program?**
- **What are urine screens?**
- **What do I do if I move?**
- **What are "carries"?**

Role of Residential Detoxification and Inpatient Treatment Facilities

Residential detoxification and inpatient services are required at timely points in individualized treatment and recovery plans. Methadone is to be maintained as an integral part of the treatment process when individuals require detoxification from substances other than opioids. During episodes of inpatient care, the continuance of prescribed methadone is to be maintained as an integral part of the client's recovery program. The logistics of managing this function are to be accomplished between the community case manager and the facility. As prescribed methadone is part of the ongoing recovery plan, the individual needs to maintain connection with a prescribing physician, a dispensing pharmacy, and her/his community case manager throughout their stay in an inpatient facility.

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5. METHADONE ASSISTED RECOVERY

In these guidelines methadone assisted recovery refers to the care and treatment of all individuals prescribed methadone for opioid dependency. Research suggests that it takes two or more years (Ball & Ross, 1991) to go through methadone treatment phases and arrive at one of three outcomes:

- long-term methadone maintenance
- medically supervised withdrawal from methadone
- methadone harm reduction

During methadone assisted recovery there may be considerable overlap and cycling between the three outcomes. Some individuals may be unwilling or unable to accept an initial goal of abstinence because they do not believe they can successfully avoid opioids completely. An important option may be to engage the individual in a process to reduce opioid use, while at the same time learn new behavioural skills, interventions, and coping strategies.

Addiction counsellors have significant roles and responsibilities once individuals are medically stabilized on methadone. Individuals direct addiction counsellors services, as in other alcohol and drug recovery processes. The following describes the roles of addiction counsellors in methadone assisted recovery.

Initial screening, problem severity assessment, assessment feedback, and recovery planning (motivational assessment process):

- Engage the individual
- Identify shifts in health status
- Prioritize problems and strengths related to drug use, physical/mental/social/legal health
- Educate about addiction, treatment options and services
- Assess and deal with immediate non-medical needs
- Assess the individual's capabilities, rehabilitation/habilitation potential

Interventions with the individual:

- Continued engagement through brief encounters
- Develop therapeutic alliance
- Model healthy behaviour
- Develop relapse prevention skills
- Intervene in crisis (as directed by the individual)
- Ongoing assessments
- Ongoing education about opioid dependency, treatment and the recovery process

The phases of methadone treatment may be described as:

1. **Initiation** – getting off illicit opioids and starting prescribed methadone.
2. **Stabilization*** – establishing an individual's therapeutic methadone dose.
3. **Determination** – identifying issues in drug use and physical/mental/ social/legal health.
4. **Action** – working on the identified issues.
5. **Maintenance** – decision time regarding methadone harm reduction, long-term methadone maintenance, or medically supervised withdrawal from methadone.

**Not to be confused with the Stabilization Stage described in Clinical Principle Four.*

"Counsellors are needed as mediators – tell us what is available."

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Interventions with the individual (continued):

- Case management and coordination
- Develop life skills
- Aftercare (for those who complete medically supervised withdrawal & those who discontinue treatment)

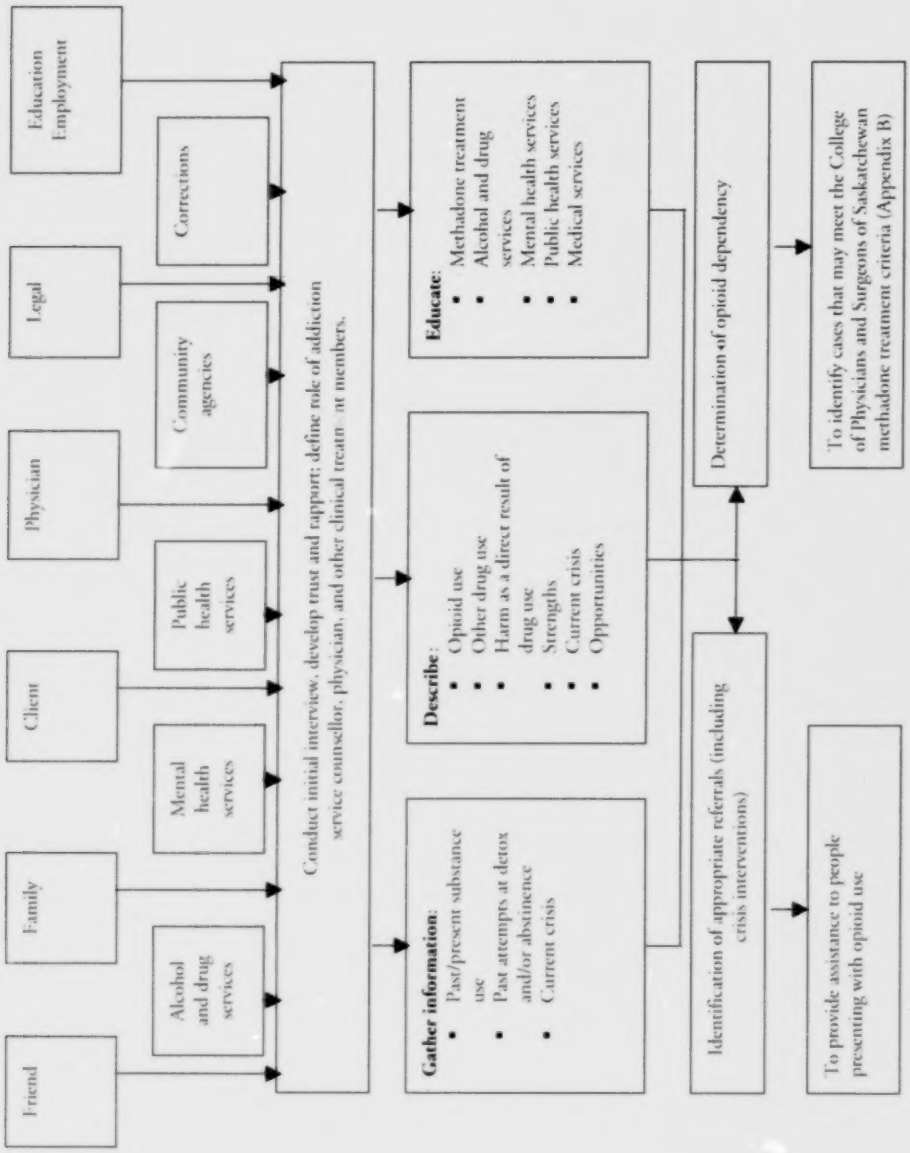
Interventions on behalf of the individual:

- Liaison with the treatment team
- Co-ordination of care/case management
- Liaison with outside agencies with whom the individual is involved
- Referrals to outside agencies (funding, therapy, upgrading, vocation work, legal counsel)
- Advocacy over non-medical issues (social or legal)
- Education of family members
- Education of community resources regarding methadone assisted recovery
- Community development (committees, boards, workshops)

Evaluation/Outcome Assessments:

- Specific case assessment and conferencing
- Data collection, individual and group
- Data analysis

6. SCREENING PROCESS



The **Screening Process** is the first step in the motivational assessment process that is to be completed by a trained addiction counsellor. The complete process involves screening, problem severity assessment, assessment feedback and recovery planning.

The addiction counsellor during **screening** seeks to:

- Identify the opioid use problems the individual is facing.
- Determine the extent to which the problems are alcohol and/or drug related.
- Determine whether it is necessary to initiate a problem severity assessment and referrals to additional services.
- Develop rapport and trust between the counsellor and the individual.
- Engage the individual so that he/she is motivated to meet again and continue with the motivational assessment process.

The screening process has four components:

- Gathering information through interviews with the individual, family member(s), and other relevant person(s) individually and/or together after obtaining the appropriate consents from the individual.
- Using screening instruments, such as the Substance Abuse Subtle Screening Inventory (SASSI), Drug and Alcohol Screening Test (DAST), Michigan Alcoholism Screening Test (MAST), Problem-Oriented Screening Instrument (POSI), Drug Use Screening Inventory - Revised (DUSI-R).
- Giving feedback to the individual and selecting future actions.
- Briefly intervening to deal with the presenting crisis.

If the screening suggests that the individual is opioid dependent, then refer the client to a methadone-prescribing physician with your rationale and recommendations. Other options include referring the individual to community-based treatment services:

- detoxification
- outpatient
- inpatient

It is recommended that the addiction counsellor continue with the Problem Severity Assessment only when an individual is sufficiently stabilized on prescribed methadone to meaningfully engage in the motivational assessment process.

Initial contact is established through an interview process with the individual. Screening information is collected in five areas:

- **Drug Use**
- **Physical Health**
- **Mental Health**
- **Social Health**
- **Legal Health**

Health conditions associated with injection drug use include:

- **Endocarditis**
- **Abscess**
- **Blot clots and embolisms**
- **Septicemia**
- **HIV and AIDS**
- **Hepatitis B, hepatitis C, and other liver diseases**
- **Cellulitus and phlebitis**
- **Adverse drug interactions**
- **Bacterial pneumonia**
- **Pulmonary complications**
- **Overdose**

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Take Home Medication

Taking methadone at home is referred to as *carries.* Carries promote the normalization of an individual's lifestyle and behaviour. Addiction service counsellors have a significant role in providing information about an individual's functional stability with regard to:

- Program participation
- Cognitive stability
- Acceptable urine screens in the last three months
- Social integration (e.g., employed, active in child care or school)

The physician decides when and if carries are to be given to an individual. Provincial guidelines do not allow carry priveleges for the first three months of treatment.

7. PROBLEM SEVERITY ASSESSMENT

Problem Severity Assessment is the second step of the motivational assessment process that is to be completed by a trained addiction counsellor who is the individual's identified case manager. The problem severity assessment has two purposes:

- To collect information about the effect of alcohol or drug use on the individual's life
- To identify strengths that can provide a foundation for recovery

Like the screening process, the problem severity assessment includes obtaining information through interviews and discussions with the individual and collatoral contacts on the following:

- Substance use history
- Family situation and history
- Psychological considerations
- Education, employment factors, finances
- Social factors (relationship to the community)
- Spiritual factors
- Medical history
- Comprehensive medical assessment

Addiction services – ongoing problem severity assessment, case management, and evaluation/outcome assessment – can be better defined, and therefore more effective, once an individual is medically stabilized on a therapeutic methadone dose. Problem severity assessment is an ongoing process between the addiction counsellor and the individual in methadone assisted recovery. The motivational assessment process provides opportunities for the addictions counsellor to:

- Give feedback to the individual
- Outline options for recovery planning
- Briefly intervene to deal with a current crisis
- Select future recovery actions and plans

Strengths, skills, experiences and resources vary considerably from individual to individual in methadone assisted recovery. It is important and sensible to work toward goals that the individual is willing to work towards. Addiction counsellor involvement with clients is focused on providing the right help at the right time by:

- Discovery/recovery of function, purpose and goals
- Development of an individual's recovery plan
- Motivation to change
- Current need/crisis

Once medically stabilized on methadone, significant improvements are often witnessed in an individual's physical, mental, social and legal health. Methadone assisted recovery provides an opportunity for the individual to address issues and make changes consistent with clinical principles found in the Saskatchewan Model of Recovery Services (Saskatchewan Health, 2000).

Continue onto the problem severity assessment only when an individual is sufficiently stable on prescribed methadone to meaningfully engage in the motivational assessment process.

"People on drugs that you used with before try to keep you using – hard to deal with getting off all the drugs – you have to deal with the cravings and all your friends are drug users."

"I like home visits, get to know us and our families, it is a change to have a straight person come to my home."

8. SASKATCHEWAN MODEL OF RECOVERY SERVICES

Methadone assisted recovery supports Clinical Principle 3 in the Saskatchewan Model of Recovery Services (Saskatchewan Health, 2000). It defines recovery as establishing/re-establishing:

- Patterns of healthy living
- Growth process
- Active process
- Comprehensive process
- Individualized process

Although time frames for the stages of recovery are very individualized, working through the stages of recovery occurs over a period of years. Clinical experience and knowledge suggests that stabilization tasks take around 18 months from the time that the individual actually starts in recovery. Completion of middle recovery task takes around 3 to 5 years from the time a person starts in recovery, and late recovery tasks take approximately 5 to 7 years.

Clinical Principle 4 (Saskatchewan Health, 2000) further defines the recovery from dependency as a developmental growth process, with specific stages and tasks, which must be completed before moving onto the next recovery stage. The stages, to the best of our current clinical knowledge and experience are:

- **Transition**
- **Stabilization**
- **Early recovery**
- **Middle recovery**
- **Late recovery**
- **Maintenance**

Transition

Individuals in this phase of recovery often struggle with the recognition of the need to abstain from all mind-altering chemicals. Providing methadone assisted recovery services may help an individual in this recovery phase. Individuals prescribed methadone may struggle with continued use of opioids and other drugs. Counselling should address these issues as a normal part of this recovery phase.

Addiction Counsellors may provide education on:

- Methadone assisted recovery – dispel myths and understand the recovery process that includes prescribed methadone (i.e., daily attendance at a pharmacy/clinic)
- Attempts to control use
- Denial/taking ownership of addiction
- Breaking the addiction cycle/lifestyle
- Sleep, exercise, nutrition
- Stress management
- Needle exchange and safe needle use
- Blood born pathogens – especially HIV and hepatitis testing and treatment, as well as hepatitis A & B immunization

Alcohol and drug services during Transition may include:

- **Screening**
- **Detoxification**
- **Outpatient counselling**
- **Referral/advocacy with other community agencies**
- **Crisis management**
- **Logistics of accessing methadone treatment (e.g., travel, payment for methadone)**

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Stabilization

Individuals in this stage of recovery need to learn to manage episodes of possible acute withdrawal from non-opioid drugs, post-acute withdrawal symptoms, as well as develop hope and motivation about recovery.

Addiction Counsellors may provide education on:

- Methadone assisted recovery regulations
- Dispelling myths
- Community based support programs (e.g. 12-Step Programs, cultural supports, spiritual supports/affiliations)
- Post acute withdrawal, assessing relapse triggers, managing cravings and euphoric recall
- Grief and loss of former friends/networks and development of new social contacts
- Substance affected family/friends/associates and boundary information
- Problem solving (e.g., addictive lifestyle, relationships involving strategies/techniques such as time management, containment and journalling)
- Cognitive skills development (e.g., planning, memory, problem solving)
- Blood-borne pathogens

Alcohol and drug services during Stabilization may include:

- **Detoxification**
- **Outpatient and/or inpatient treatment**
- **Crisis management**
- **Referral/advocacy with community agencies**
- **Problem severity assessments**
- **Assessment of relapse triggers**
- **Exposure to twelve step programs and/or methadone support groups**
- **Logistics of accessing community services**

Early Recovery

Individuals in this phase of recovery develop short-term stability, understand the impact of addiction, learn non-chemical stress management and develop a recovery-centered value system.

Addiction Counsellors may provide education on:

- The development of a recovery-based value system
- Financial Management
- Boundaries in relationships
- Vocational counselling/school/work/volunteer
- Parenting, self image
- Resolving outstanding legal issues
- Containment/stabilization strategies for people showing signs/symptoms of trauma
- Relapse prevention

Alcohol and drug services during Early Recovery may include:

- **Outpatient addictions counselling**
- **Accessing vocational and financial counselling services,**
- **Accessing school, training, or employment programs**
- **Accessing mental health services regarding trauma issues**

Middle Recovery

Individuals in this stage develop a self-regulated recovery plan, establish lifestyle balance, resolve social damage resulting from substance use, and learn to manage change.

Addiction Counsellors may provide information on:

- Renewing or establishing social contacts/outlets
- Family communications, parenting
- Accessing services at other agencies regarding marriage/couple issues, career changes, reaching goals, managing change, recognizing and achieving lifestyle balance

Alcohol and drug services during **Middle Recovery** may include:

- Outpatient services
- Accessing mental health services
- Accessing vocational and financial counselling services
- Accessing family counselling services

Late Recovery

Individuals in this stage resolve family of origin issues, develop intimacy skills and integrate recovery values and behaviours into all aspects of their lives.

During **Late Recovery**, recovery is usually self-directed and the person will access community-based services as needed. Outpatient alcohol and drug services can provide support during crises.

Stabilization

Individuals in this stage of recovery need to learn to manage episodes of possible acute withdrawal from non-opioid drugs, post-acute withdrawal symptoms, as well as develop hope and motivation about recovery.

Addiction Counsellors may provide education on:

- Methadone assisted recovery regulations
- Dispelling myths
- Community based support programs (e.g. 12-Step Programs, cultural supports, spiritual supports/affiliations)
- Post acute withdrawal, assessing relapse triggers, managing cravings and euphoric recall
- Grief and loss of former friends/networks and development of new social contacts
- Substance affected family/friends/associates and boundary information
- Problem solving (e.g., addictive lifestyle, relationships involving strategies/techniques such as time management, containment and journalling)
- Cognitive skills development (e.g., planning, memory, problem solving)
- Blood-borne pathogens

Alcohol and drug services during **Stabilization** may include:

- Detoxification
- Outpatient and/or inpatient treatment
- Crisis management
- Referral/advocacy with community agencies
- Problem severity assessments
- Assessment of relapse triggers
- Exposure to twelve step programs and/or methadone support groups
- Logistics of accessing community services

Early Recovery

Individuals in this phase of recovery develop short-term stability, understand the impact of addiction, learn non-chemical stress management and develop a recovery-centered value system.

Addiction Counsellors may provide education on:

- The development of a recovery-based value system
- Financial Management
- Boundaries in relationships
- Vocational counselling/school/work/volunteer
- Parenting, self image
- Resolving outstanding legal issues
- Containment/stabilization strategies for people showing signs/symptoms of trauma
- Relapse prevention

Alcohol and drug services during **Early Recovery** may include:

- Outpatient addictions counselling
- Accessing vocational and financial counselling services,
- Accessing school, training, or employment programs
- Accessing mental health services regarding trauma issues

Middle Recovery

Individuals in this stage develop a self-regulated recovery plan, establish lifestyle balance, resolve social damage resulting from substance use, and learn to manage change.

Addiction Counsellors may provide information on:

- Renewing or establishing social contacts/outlets
- Family communications, parenting
- Accessing services at other agencies regarding marriage/couple issues, career changes, reaching goals, managing change, recognizing and achieving lifestyle balance

Alcohol and drug services during **Middle Recovery** may include:

- Outpatient services
- Accessing mental health services
- Accessing vocational and financial counselling services
- Accessing family counselling services

Late Recovery

Individuals in this stage resolve family of origin issues, develop intimacy skills and integrate recovery values and behaviours into all aspects of their lives.

During **Late Recovery**, recovery is usually self-directed and the person will access community-based services as needed. Outpatient alcohol and drug services can provide support during crises.

9. OTHER ISSUES RELATED TO METHADONE ASSISTED RECOVERY

Transfers to Other Methadone-prescribing Physicians

Transfer arrangements should be set up ahead of time whenever possible to avoid interruption of methadone treatment and to minimize inconvenience to the client, other methadone prescribers, dispensing pharmacies and institutions. Addiction counsellors may be required to co-ordinate the transfer of a client to another methadone-prescribing physician.

The following information should be forwarded to facilitate a transfer:

- Addiction counsellor screening form
- Copy of most recent methadone prescription with expiry date
- List of any other prescribed medications
- Witnessed drink/carry information
- Physician's treatment plan/evaluation documentation
- Motivational assessment report and other information regarding the individual's recovery plan

Addiction counsellors may also be involved in arranging for 'courtesy dosing' for clients visiting from or going to locations outside of your community.

Methadone & Pregnancy

The primary intent of methadone assisted recovery for an opioid dependent pregnant woman is to create a stable environment for the pregnancy and to improve maternal and neonatal outcomes. Methadone does not impair the child's developmental and cognitive functioning and is the recommended course of treatment for most opioid dependent pregnant women. Women who are addicted or abusing opioids do better with methadone than with no treatment (Lindesmith Centre, 1996).

Information is to be provided to women regarding the role of methadone assisted recovery in pregnancy. Client information can be found in **Appendix E**.

Concurrent Disorders

Research indicates that mental health issues are to be expected in opioid dependent individuals. Many clients in methadone assisted recovery may have mental health issues that have been undiagnosed, misdiagnosed, untreated or ineffectively treated due in part to on-going drug use.

During the initial screening interview, it is important to explore and document the individual's mental health/psychiatric history. This may include any past diagnoses, contacts with a psychiatrist or mental health personnel, hospitalizations, medications taken and perceived effect by client, personal struggles with stress, anxiety, depression, childhood trauma, head trauma, suicide attempts and major losses/grief. It is also important to examine present issues, mood states, currently prescribed medications, illicit drug use to manage symptoms, assessing risk to the individual or others, and contact with psychiatry.

Stabilization on prescribed methadone allows for a clearer, more accurate assessment of mental health symptomology. Accurate assessment allows for appropriate diagnosis, treatment and/or referral for treatment.

Research supports providing treatment for addiction and mental health issues simultaneously thus co-ordination of care is imperative. The goal for individuals is to achieve stability and return of function in both areas.

Adolescents

Best practice information identifies a need for older youth to have access to methadone assisted recovery. They require safe living environments in order to participate in addiction recovery services and to maintain regular appointments with the services required as part of a recovery plan. As youth may distrust systems, significant effort needs to be made to build trust with youth and engage them in accessing services.

As more knowledge and experience has been gained through methadone assisted recovery programs, individual circumstances have indicated the need to provide prescribed methadone to younger adolescents.

Detoxification, stabilization, support, and outreach services have been shown to be effective strategies with youth presenting with substance use. These services are particularly important for marginalized youth involved in injection drug use (Currie, 2001).

Offenders in Custody

Evidence shows there is a significant reduction of injection drug use in prisons among offenders prescribed methadone for opioid dependency. In a 1998 study, Darke, Kaya and Finley-Jones show that higher methadone doses in prison were associated with less injection drug use, a fact that is consistent with community studies.

It is important that individuals on prescribed methadone while incarcerated, are referred to community based agencies at discharge or on release dates. It is preferrable to plan the referral, but at a minimum, to send a notification to the community-based agency when an unplanned release occurs.

In April 2002, Correctional Service Canada's methadone policy was revised to allow the initiation of methadone treatment while incarcerated. Saskatchewan's Department of Corrections and Public Safety revised its methadone treatment policy in June 2003 to initiate treatment while in provincial correctional institutions. For more information on the Corrections & Public Safety Methadone Policy please see **Appendix F**.

10. CO-MANAGEMENT OF RECORD KEEPING IN METHADONE TREATMENT

Good communication among physicians, addiction counsellors, pharmacists, and other healthcare providers is essential to protect the privacy and confidentiality of health information in the co-management of individuals prescribed methadone for opioid dependency. The addiction counsellor will comply with federal and provincial regulatory requirements.

The sharing of information between addiction counsellors and physicians, and vice-versa, requires a signed client consent form authorizing communication and release of information. The information that is to be shared shall be on a need to know basis and applicable to the medical management and treatment of the client.

The addiction counsellor is to obtain signed, informed consent from the individual before commencing the screening process to intake an individual into methadone assisted recovery.

A signed treatment agreement between the physician and client details comprehensive care for the opioid dependent individual that includes methadone, medical, addiction, and other health, social and legal services. The treatment agreement directs those involved in the care and treatment of the individual to advise and share healthcare information as required on a need to know basis.

The physician's medical chart is the **primary** record. The medical chart is to include the following information from the addiction counsellor's file:

- Screening information that may include recommendation and treatment plan
- On-going addiction counsellor progress notes
- Release of Information/Consent forms
- Copies of referrals made by the addiction counsellor
- Saskatchewan Health, Alcohol and Drug Admission/Discharge Forms

For more information on recordkeeping please see **Appendix G**.

Physician's Medical Chart

- Demographics
- Track Sheet
- Treatment Plan
- Release of information/Consent Forms
- On-going progress notes
- Record of medications prescribed
- Signed Treatment Agreement
- Collateral information (from referral source, family doctors, addiction counsellors, community resources and education (formerly social services), College of Physicians and Surgeons, Justice, jails, hospitals etc.)
- Witness drink/Carry request sheets
- Information/requests from community resources
- Evaluation documentation

The addiction counsellor's file is the **auxiliary** record. For a complete description of the involvement of other community resources, please see **Appendix H**.

10. CO-MANAGEMENT OF RECORD KEEPING IN METHADONE TREATMENT

Good communication among physicians, addiction counsellors, pharmacists, and other healthcare providers is essential to protect the privacy and confidentiality of health information in the co-management of individuals prescribed methadone for opioid dependency. The addiction counsellor will comply with federal and provincial regulatory requirements.

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APPENDIX A

TERMINOLOGY

ADDICTION: Addiction is a primary, chronic, neurobiological disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviours that include one or more of the following (3 C's):

Impaired **C**ontrol over drug use

Compulsive use

Continued use despite harms (**C**onsequences)

COURTESY DOSING: A request made by the primary methadone prescriber for interim dosing for individuals on prescribed methadone who may be residing temporarily in another location (e.g. while they are away from home).

CRAVING: A bio-psychological arousal and urge to return to addictive behaviour, characterized by a strong desire, pre-occupation and possible impulsivity.

DIVERSION: Prescribed medication, including methadone, being used illegally by persons who receive it from an individual for whom it is prescribed.

OPIATE: A substance derived from or containing opium. Thus all opiates are opioids. Opiates include morphine and codeine.

OPIOID: An all-inclusive term, which describes drugs with morphine-like activity, whether natural products of opium, semi-synthetic like heroin, or hydromorphone (Dilaudid) or entirely synthetic like meperidine (Demerol) or methadone.

PHYSICAL DEPENDENCY: Physiological state of adaptation to a specific psychoactive substance characterized by the emergence of a withdrawal syndrome during abstinence which may be relieved in total or in part by re-administration of the substance.

PSYCHOLOGICAL DEPENDENCY: A subjective sense of need for a specific psychoactive substance, either for its positive effects or to avoid negative effects associated with its abstinence.

RECOVERY: Recovery is defined as the BEST RETURN OF FUNCTION, which may or may not include abstinence from drugs.

THERAPY: For the purposes of this document, therapy is a combination of prescribed methadone and counselling services.

TOLERANCE: State in which an increased dosage of a substance is needed to produce a desired effect.

COLLEGE OF PHYSICIANS AND SURGEONS OF SASKATCHEWAN METHADONE TREATMENT ADMISSION CRITERIA

1. NEW PATIENTS, NOT YET ON METHADONE

(1) The patient must want to be treated.

(2) Dependency/Addiction must be established.

(3) There should be evidence of extensive past and current opiate/opioid use and:
failed attempts at personal withdrawal and / or
failed attempts at structured/residential "detox" and / or
failed treatment attempts.

(4) No age limit.

(5) Previous unsuccessful Methadone treatment should not exclude a patient from further Methadone treatment.

2. EXISTING PATIENTS - TRANSFERS FROM OTHER METHADONE PRESCRIBERS

(1) Collect all the transfer information from the other clinic.

(2) Continue methadone as before.

(3) Reassess as time goes on, and adjust as necessary.

See Section on Transfers Between Methadone Facilities

3. PREVIOUS PATIENTS and / or RESTARTS FROM OTHER METHADONE PRESCRIBERS

(1) Collect all the transfer information from the other clinic.

(2) Note difficulties the other Clinic(s) may have had.

(3) Restart methadone according to the Guidelines in Dosing section.

(4) Reassess as time goes on, and adjust as necessary.

For all of the above obtain:

(1) Past medical history from their family physician and

(2) their Triplicate Prescription Program information from the College of Physician and Surgeons of Saskatchewan.

APPENDIX C

TREATING OPIOID DEPENDENCY THROUGH METHADONE

What is Methadone? Methadone is a painkilling medication discovered in the 1940s by German scientists as a substitute for morphine. Later, researchers found that methadone could be used to treat opioid withdrawal. It was not until the 1960's in Vancouver BC that methadone was first used to treat opioid addiction.

What is it used for? Methadone is used to treat opioid dependency. Examples of opioids include heroin, codeine, morphine, hydromorphone (Dilaudid) and meperidine (Demerol).

How does it work? Methadone has unique actions other than pain relief. When taken daily at the proper dose, methadone prevents physical withdrawal (dope sickness) and physical cravings for opioids for about 24 hours. The right dose of methadone does not make a person feel 'high' or 'drugged' like other opioids do, allowing a person to live a normal life. Methadone is taken daily as a 'drink' mixed with flavoured fruit juice, allowing the opioid dependent/addicted individual to stop injecting drugs. This decreases their risk of contracting blood-borne diseases like HIV/AIDS and Hepatitis.

The long-term goal of methadone assisted recovery is to aid people in 'return of function'. Success is measured by an individual's level of functioning in various areas of life – not by the amount of methadone they are taking. Methadone can help the opioid dependent/addicted individual live a healthier, more productive life, free of illegal drugs.

Is methadone safe? Research has shown that methadone is as safe as other medications when it is taken as prescribed by a doctor. Methadone does not damage any of the body's organs. It allows individuals to think more clearly so that they can learn new skills. When people are taking a stable dose, methadone does not interfere with their ability to go to school, work, drive or parent. Methadone is not safe for people it was not prescribed for in fact, it could cause their death.

How much methadone does a person need? The right dose of methadone varies for each person. The proper dose keeps a person from having withdrawal symptoms between doses. It will also stop physical cravings for opioids and prevent individuals from getting high if they do take opioids.

Are there adverse effects? As with any medication, some people may experience adverse effects. When starting methadone treatment adverse effects may include nausea, sleepiness, sweating and constipation. As a person becomes stable on the medication these adverse effects usually disappear, become less intense, or might be eliminated with a dose change.

What can a person expect? Taking a prescribed medication, methadone, is one of the first steps in methadone assisted recovery. Individuals in methadone assisted recovery are expected to make daily trips to a pharmacy for a witnessed drink. Once stable on methadone, a person can "do the work" in the other areas of their life. The areas to be repaired and to learn new skills in include drug use, physical health, mental health, social health and legal health. Methadone alone does not cure opioid dependency. It is used as part of a holistic recovery program, which includes support, education, and skill development. Talk to your doctor, addiction counsellor, pharmacist, family, friends and successful methadone clients for education and support.

How long will treatment take? There is no set time for methadone assisted recovery. In general, the longer a person stays in treatment, the greater their chance of success. Some people take methadone their entire life because it keeps them stable and functioning well. Others choose to "wean off" methadone

once they have returned to full function. Individuals are encouraged to make realistic plans with their treatment team and to discuss their progress. They should never reduce their dose or stop taking their methadone on their own as they may experience withdrawal symptoms and drug cravings that set them up to relapse.

What will it cost? There may be a weekly charge for your methadone depending on your prescription drug coverage—check with your pharmacist.

Benefits of methadone treatment

- Better general health
- Better access to health care
- Greater psychological well-being
- Better home and work life
- Less spread of infectious diseases like HIV/AIDS and Hepatitis
- Improved ability to seek employment and education
- Improved memory and thinking
- Less drug-related theft and property crime
- Less reliance on welfare
- Less illicit drug use, fewer deaths
- Less violence
- Improved ability to parent and care for children
- Improved self-esteem and social functioning
- Safer communities

Challenges of methadone treatment

- Highly regulated, long-term form of treatment.
- Methadone is dangerous, potentially fatal to non-opiate dependent people
- Risk of diversion is real and serious
- Side effects trouble some people.
- Participation in methadone treatment may be stigmatizing for clients.

Talk to others. Get accurate information. Share your experiences. Ask questions.

Log on to:

APPENDIX D

WHAT DO I NEED TO KNOW ABOUT METHADONE ASSISTED RECOVERY?

Why are there rules in methadone assisted recovery?
Methadone is a controlled substance. This means that there are federal and provincial regulations and guidelines that need to be followed. Doctors and pharmacists are subject to regulations that they must follow without exception when they prescribe or dispense methadone.

Are all methadone assisted recovery expectations the same?
Although the rules about your methadone assisted recovery program may vary somewhat depending on where you live, there are a few basic rules that you need to know.

The most important rule is to find out what is expected from you and what you can expect from those involved in your treatment. There are a number of people on your treatment team – doctors, pharmacists, counsellors, clinic/office staff and perhaps others. Although rules can be hard to live with, there are reasons for them. In the end they are there for your benefit.

What are some of the rules?

- Appropriate and respectful behaviour toward your treatment team, the clinic/office staff and other individuals.
- Urine screens may be requested at any point in your treatment and must be provided.
- Using street drugs is not helpful in recovery, yet people sometimes use. Urine screening is a way to help determine what your recovery needs are and allows the team to work with you on an individual basis.

What do I do if I move?
Notify your doctor or clinic well in advance of a move to a new location. To ensure continuation of your methadone prescription, all transfers to new locations should be arranged before your move. Talk to your doctor about making the arrangements needed to prevent disruption of methadone.

What are "carries"?
Everyone who starts methadone treatment is expected to go to a pharmacy daily to have what is called a witnessed drink. This means that you take your methadone at the pharmacy every day under the supervision of a pharmacist.

Taking methadone at home is called carry privilege. Provincial guidelines do not allow carry privileges for the first three months of treatment. After that, carry privileges can be discussed with your doctor. In many cases, when people are stabilized on methadone they become employed, active in childcare or enroll in school. These may be reasons to ask for take-home medication.

A minimum of 48 hours notice is needed for all carry requests. We all take vacations and attend social events that require us to be away from home. Part of being in methadone assisted recovery is taking responsibility for the continuation of your methadone by planning in advance.

APPENDIX E

METHADONE ASSISTED RECOVERY AND PREGNANCY

If you are abusing opioid drugs and pregnant, or thinking about becoming pregnant, this section may answer some important questions you have about the effects of opioid use on your unborn child. This section will also provide information about methadone treatment and pregnancy that may help you and your baby.

What are the benefits of methadone assisted recovery during pregnancy?
Methadone has been used for many years as a safe and effective treatment for opioid dependency. Methadone will not harm you or your baby when it is taken as prescribed by your doctor.

There are a lot of good reasons to consider methadone assisted recovery if you are pregnant.

- Decreased exposure to blood-borne diseases such as HIV/AIDS and Hepatitis
- Decreased risk of premature labour, low birth weight, miscarriage and stillbirths
- Improved nutrition during pregnancy
- Allows you to make healthy life style changes

What are the risks of continued opioid use when pregnant?
Continued street use of opioids (like morphine, heroin, and hydromorphone [Dilaudid]) while pregnant can cause complications for you and your baby. Continued street use increases the risk of premature labour, miscarriage, stillbirths and sudden infant death syndrome (SIDS). There is always a risk of exposure to a blood-borne disease for you and your baby through injection drug use.

How does methadone affect my baby?
Because methadone crosses from mom to baby while in the womb, your baby may experience some withdrawal symptoms following birth. This is called neonatal abstinence syndrome. The doctor will determine if your baby is in withdrawal and can easily treat these symptoms. Moms taking methadone are encouraged to breast-feed their babies like any new mother. You are encouraged to discuss any concerns that you may have with your doctor. There are no long-term effects to a baby from methadone. Methadone treatment is always the better choice if you are addicted or abusing opioids.

What dose should I be taking during my pregnancy?
The right dose of methadone during pregnancy is individual and best determined by you and your doctor. Certain changes occur during pregnancy that may affect the level of your methadone dose. It is important to discuss any symptoms of withdrawal or craving with your doctor. Stopping or decreasing your methadone dose during pregnancy is not recommended. It could put you and your baby at risk.

Will I still get methadone in the hospital?
Be sure to tell the hospital staff that you are receiving methadone to ensure the continuation of your methadone while in hospital. You can be treated for pain during labour and delivery like any other patient.

Saskatchewan

APPENDIX F

CORRECTIONS AND PUBLIC SAFETY POLICY

TOPIC: METHADONE TREATMENT FOR OFFENDERS		
LEGISLATIVE AUTHORITY:	EFFECTIVE DATE: **October 5, 1998**	REVISED **June 2003**

PURPOSE

The purpose of this policy is to provide standards for the Methadone Treatment Program for persons incarcerated in provincial correctional centres.

PRINCIPLE

Corrections has a duty to assist an offender to achieve better health by:

- Facilitating recognized medical intervention.
- Supporting the harm reduction model as a strategy for reducing the transmission of communicable diseases.

DEFINITION

Methadone is a synthetic narcotic medication prescribed for the symptomatic treatment of addiction to opioids.

Methadone prevents withdrawal symptoms and helps reduce cravings.

STANDARDS

1.0 General

1.1 Correctional centres that have medical units are responsible for co-operating with the directions provided by the medical authorities who provide Methadone Maintenance Treatment services. This co-operation includes facilitating an offender who is established on Methadone Treatment to continue on this program, and providing the physician who is prescribing the methadone with information about the offender's circumstances throughout the period of incarceration. (e.g., program involvement, release plans, changes in sentence status.)

1.2 An offender who is established (i.e., not in the transition phase) on the Methadone Treatment Program when admitted to a correctional centre will be maintained on this treatment while held at the correctional centre, subject to the approval of the methadone prescribing physician.

CORRECTIONS AND PUBLIC SAFETY POLICY

TOPIC: METHADONE TREATMENT FOR OFFENDERS		
LEGISLATIVE AUTHORITY:	EFFECTIVE DATE: **October 5, 1998**	REVISED **June 2003**

1.3 An offender who is not on the program at the time of admission may be considered for such treatment while incarcerated when referred by a physician and assessed by a qualified Methadone prescriber as being appropriate for the treatment.

1.4 In circumstances when the contracted physician refers an offender who is not already established on MMT Program to a Methadone prescriber, the Correctional Centre Director will immediately notify the Executive Director of Corrections. The notification will serve as the authority for the Correctional Centre Director to facilitate the Methadone prescriber's direction.

1.5 The Correctional Centre Director is responsible for establishing a written agreement between the physician exempted to prescribe methadone and the correctional centre's contract physician about:

- the procedures that apply to an offender being maintained on the Methadone Treatment Program;
- the procedures that apply to this same offender for receiving other health care services from the correctional centre's contract physician.
- The capacity for treatment (section 4.0 of this policy)

1.6 An offender wishing to participate in the Methadone Maintenance Program must sign a consent agreement (Appendix A). No methadone shall be administered without a signed agreement.

1.7 The Correctional Centre Director is responsible for establishing a process whereby all offenders on the Methadone Maintenance Program are photographed.

1.8 The Correctional Centre Director will establish local procedures to ensure the identity of the offender is verified before administering the methadone.

1.9 All offender photographs will be locked in a secure area when not being used for methadone administration.

2.0 Supply and Control of Methadone

2.1 The Correctional Centre Director is responsible for developing local procedures to facilitate receiving, storing, and distributing methadone as prescribed by the appropriate medical authority. These procedures will comply with the Corrections Policy on Pharmacy Services (Medical - 0001) and will include having methadone supplied in sealed containers.

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2.2 Under no circumstances shall the methadone supplies for an offender be placed in his/her personal property effects.

2.3 An offender receiving Methadone Treatment is eligible to participate in correctional centre programs except or unless:

- the prescribing physician recommends the offender not participate in an activity. (e.g., operation of equipment);
- the program the offender wants to participate in results in the offender being unavailable to receive the medication from the medical staff at the prescribed times. (e.g., Urban Camp Work Crew), unless alternative times have been established for special events/programs (e.g., Visiting, Sweats).

2.4 Methadone medication may be conveyed with persons accompanying an offender when being escorted, transferred or in transit for court purposes.

2.5 An offender who is established on methadone treatment will not be allowed "carrying privileges" for methadone within the correctional facility and will not be provided with methadone on release. Any remaining methadone will be returned to the pharmacy or disposed of as per the Narcotics Control Act. The offender will be assisted in arranging an appointment with the prescribing physician on release to ensure continuation of the treatment program.

3.0 Administration of Methadone

3.1 Methadone medication must be given under the direct supervision of medical unit staff.

3.2 The nurse will verify the identity of the offender before administering the methadone.

3.3 The offender will consume a full glass of water after ingesting the methadone and the nurse shall verify that the medication is not held in the mouth.

3.4 The offender shall be observed by correctional staff for approximately 20 minutes after the administration of methadone to ensure methadone ingestion, with no regurgitation. Ideally, the observation will occur in designated supervised areas.

4.0 Capacity for Treatment

4.1 When the demand for methadone currently surpasses the ability of the correctional centre to safely manage the storage and delivery of the medication to these offenders, priority for

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methadone initiation will be given to offenders who meet the following criteria:

- Remand and sentenced women who are pregnant and currently opioid dependent or were previously opioid dependent and are a high risk of relapse
- Remand and sentenced offenders who are currently opioid dependent.
- Opioid dependent offenders who require treatment for Hepatitis C and HIV.

4.2 Each correctional centre, in consultation with the physician who is prescribing the methadone must determine on a continual basis the patient load they can safely and responsibly maintain as evidenced by adherence to the parameters outline in the Saskatchewan Methadone Guidelines for the Treatment of Opioid Addictions.

5.0 Review of Program

5.1 The Correctional Centre shall conduct a review of the offender's participation in the program if the offender displays any of the following inappropriate behavior:

- is unco-operative or non-compliant in receiving the medication and/or conditions of the contract;
- alters or attempts to alter a urine sample;
- the offender's behaviour indicates the offender is under the influence of illicit drugs, or appears to be having an adverse reaction that could endanger the offender's health;
- the offender is abusing other prescribed medication;
- the offender has tested "dirty" on drug screen tests or the tests are negative for methadone;
- the offender has been found guilty of trafficking in illicit substances while on the MMT Program.

5.2 The decision to remove an offender from the Methadone Maintenance Program is a medical decision, and will be made by the centre's medical staff in consultation with the methadone physician treating the offender.

5.3 Drug screen testing that is required to maintain the integrity of the offender's Methadone Treatment Program will be conducted on the direction of the prescribing physician, or as established in the "Provincial Protocol on Recovery Services for Opioid-Dependent Clients (Methadone Component.)" Results of the drug screen tests will be shared with the nursing unit. A disciplinary charge or other security measures may be considered in instances when an offender has tested "dirty" on a drug screen test after consultation with the prescribing methadone physician.

CORRECTIONS AND PUBLIC SAFETY POLICY

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5.4 The correctional centre's nursing unit in consultation with the methadone prescribing physician and the correctional centre physician will make provision for an offender on the Methadone Treatment Program to receive over-the-counter medication, as may be required due to the side-effects of using methadone. (e.g., medication for nausea or constipation as ordered by the prescribing physician.)

6.0 Intermittent Offenders

6.1 Intermittent offenders reporting to the Correctional Centres shall bring their Methadone 'carries' in a tamper proof, sealed container. The container shall be inspected by the nursing staff to verify it has not been adulterated or tampered with.

6.2 Intermittent offenders who do not have carry privileges must provide the nurse with the name of the methadone prescribing physician and dispensing pharmacy.

EFFECTIVE DATE

This policy is effective as indicated.

Terry Lang
Executive Director of Corrections

Saskatchewan

APPENDIX F

CORRECTIONS AND PUBLIC SAFETY POLICY

TOPIC: METHADONE TREATMENT FOR OFFENDERS		
LEGISLATIVE AUTHORITY:	EFFECTIVE DATE: **October 5, 1998**	REVISED **June 2003**

Agreement to Participate in Methadone Maintenance Program **Date:**_____

I, _____, understand that the centre will continue to provide my methadone during my period of incarceration, and that I freely choose to control my use of opioid drugs by using methadone as prescribed by my physician.

I further understand and agree that:

1. My prescribing physician has determined that methadone is appropriate and safe for me, and that my prescribing physician shall determine what dosage of methadone is appropriate for me.
2. Methadone will be administered to me daily, and I will drink a glass of water after receiving my dose of methadone and be observed for a determined period of time. I also understand that methadone can be dangerous or even lethal if consumed by a person who is not tolerant, and that my methadone dose will be consumed by me alone.
3. I will provide urine samples for drug screening purposes, the frequency of such to be determined by the prescribing physician. I also understand that my methadone may be discontinued or used for security or discipline purposes if a drug screen test positive for any illicit substances.
4. I will only take medications other than methadone that are prescribed by the centre's physician. I understand that to do so may result in serious health problems, overdose, or even death.
5. I agree to sign a release of medical information to allow my prescribing physician and/or the community clinic where I was receiving methadone, to share information with correctional health care staff concerning medical issues related to my methadone maintenance.
6. I agree to participate in any substance abuse program as directed by my case manager.
7. My methadone may be discontinued for inappropriate behaviours related to the program such as use of illicit substances, not taking my prescribe dose of methadone, attempting to alter my urine sample or trafficking in illicit substances.
8. I understand I may voluntarily choose to discontinue my program of methadone maintenance at any time.
9. I acknowledge that methadone in my possession on admission will not be place in my personal property and, further will be destroyed in accordance with federal requirement (excluding Intermittent offenders)

Understood and signed by: Witnessed by:

_____ _____

APPENDIX G

RECORDKEEPING

Methadone treatment team	**Examples of information usually shared between team members**	**Rationale for sharing information**
Methadone-prescribing Physicians	• Clinical notes • Medical assessments • Prescriptions • Carry forms • Drugs of abuse testing results • Psychosocial assessments • Treatment agreement & plan	• Safety • Intake/discharge • Diagnosis • Monitor treatment progress • Case conference • Referrals
Methadone-dispensing Pharmacists	• Dispensing history/dose • Changes in patient/client behaviours and/or attitudes from directly observed therapy • Prescription drug coverage	• Safety • Monitor treatment progress • Case conference • Referrals
Alcohol & Drug Counsellors	• Intake screening/ recommendations • Problem severity assessments • Treatment/Recovery plans • Clinical notes • Alcohol and Drug Services Client Intake/Discharge forms	• Safety • Crisis intervention • Monitor treatment progress • Case conference • Referrals
Other resources	**Examples of information that may be shared with team members**	**Rationale for sharing information**
Family physician	• Past medical record • Past treatment for dependence/addiction	• Intake • Discharge • Medical referrals
College of Physicians and Surgeons of Saskatchewan	• Narcotic/Methadone history from the Triplicate Prescription Program (shared with treating physician only)	• Safety • Physician educational audits
Mental Health Counsellors	• Mental Health history • Clinical notes • Mental Health Services (MHS) Client Intake/Discharge forms • Medication/dosage	• Safety • Crisis intervention • Monitor treatment progress • Case conference • Referrals

Public Health Nurses	• Client/patient information :
	  ○ Immunization
	  ○ Needle exchange information
		• Surveillance
		• Testing
		• Partner notification under Public Health Regulations

Community Service Personnel	• Case Assessments • Family legal issues • Custody of children	• Child protection • Family support • Income support
Police Officers	• Contact with police regarding illegal activities • Convictions/Arrest Warrants • Probation/parole conditions	• Safety • Monitor progress • Clients/patients in custody • Referrals
Correction Workers	• Correctional Release Plans, including release conditions • Risk Assessments • Probation/Parole conditions	• Same as police • Release planning
Hospital Personnel	• Continuity of care • Referrals	

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Hospital Personnel	• Continuity of care • Referrals	

APPENDIX H

METHADONE ASSISTED RECOVERY SERVICES CONTACT INFORMATION

Directory Of Methadone Clinics,
Alcohol & Drug, and Addiction Services
Please call your health region or visit the following website:
http://www.health.gov.sk.ca/ps_ads_directory.html

Directory Of Methadone Prescribing Physicians
Please call the College of Physicians and Surgeons of Saskatchewan
Telephone: (306) 244-7355
Fax: (306) 244-0090
E-Mail: leea@shin.sk.ca
http://www.quadrant.net/cpss/

Directory Of Methadone Dispensing Pharmacies
Please call the Saskatchewan Pharmaceutical Association
Telephone: (306) 584-2292
Fax: (306) 584-9695
E-Mail: saskpharm@sasktel.net
http://www.napra.org/docs/0/203/262.asp

APPENDIX I

FOCUS GROUPS WITH INDIVIDUALS IN METHADONE ASSISTED RECOVERY

Locations: Saskatoon, Prince Albert and Regina

Dates: March, April and May 2003

Process: Individuals on prescribed methadone were invited to attend a group session and give their views and opinions. A topic list was developed for the focus groups and people were welcome to respond or provide information as they wished. Participation was voluntary and the opinions expressed are individual's comments recorded in their words.

Intake

- It shouldn't take so long (to get on the program) – 2 weeks waiting is like a year
- I had to move to the place where the program is
- Usually wait a month – quicken things up - you are sick and shaking and they tell you to wait a month –(another person got meth the first day in Ontario) – practically impossible to get it in rural areas (as) no doctor is available
- The clinic (one location) looked down on you
- Addicts always want it easy, maybe should wait
- Should cut morphine by a third – people are drawn to the program by the morphine – Kadian is a super idea – needed something to get me through – 30 mg of meth is not enough yet (at the beginning) – I kept using some until up to 90 mg
- People should be kicked off if not following the program, should have to prove you are serious – give a little bit of leeway - there has to be some understanding - I was still using pot and valium but was serious – if they are staying out of jail, not pimping and robbing then they are doing good, less than before - leave on the program
- I had months of pure hell everyday doing things I wished I had never done
- People don't know that if you aren't a needle user you can still go on the program
- Difficult getting on the meth – I was 3 weeks clean but had to test positive to get on the program, used again and had another month of using before getting on the program
- It is a problem getting doctors to understand your need for opiates after addicted
- Meth was the only thing that stopped me from using, I had only gone 2 days on my own, was shoving needles from age 18 to 31 and now am 33
- I now have 5 years of not using
- Really screen people, I know people who got on meth then 'sniffed' and died
- Sometimes people don't keep appointments, can't get a sitter, have real reasons for missing
- Some are still hanging onto the old lifestyle and will not go anywhere

Client Orientation

- Just seeing my boyfriend getting better on meth helped me through the waiting period
- Difficult withdrawal (pain) leads you back to using even though you really want to get clean

- Tell us all the symptoms, talk about it, e.g. constipation, I had to change my eating patterns - give us this information in a regular newsletter – distribute the information at the pharmacy
- Clinic should have orientation sessions – those on meth don't know all effects e.g. teeth
- People on drugs that you used with before try to keep you using – hard to deal with getting off all the drugs – you have to deal with the cravings and all your friends are drug users
- It is hard to get off all the drugs even if meth is at a high dosage
- Know people who have had meth and then used other drugs then went to sleep and died
- I didn't know the dangers of mixing drugs
- The first 3 – 4 days you need transportation until stable – should be provided rides, even when walking home you are throwing up and drowsy – at first you feel so bad you do not even want to get out of bed and walk in the winter or take your kids with you
- Being on meth really changes your life – feel tethered to the clinic - Being on the program really restricts your movements
- People need to know what the withdrawal program or process is
- People need to know how to be weaned off of meth
- Workshops in treatment places are awesome, helpful – I would do them over again
- Pharmacists are very helpful, front line
- You can't do the program in two months – get a support number and use it
- Find out where you can go for cheap fun, keep busy every day, e.g. Friendship Centre – keep busy to not think about cravings - avoid downtown where you used to use
- I got too concerned about getting off meth and set myself up for a relapse
- You hear good and bad about all counsellors, stick with the program
- Nice to have one (an AC), not everyday, but you can talk to someone when you want to – it is stupid to not talk to a counsellor – if you don't talk to one you are setting yourself up for relapse
- Explain about urine tests and what it is all about

Special Populations

- Meth is trendy for young people
- Young people should be on birth control
- EGADZ is good for young people, needed for adults too

Addiction Counsellor Roles and Responsibilities

- You should have addiction counsellors – they should identify our problem areas, this should be a group effort not just the doctor
- Identify the problems right away and get working on them, that is why you are an addict e.g. past abuse – there are underlying reasons for using street drugs and these must be identified in order to overcome addiction – after being involved with the program a while I was encouraged to deal with my problems
- There should be boundaries, people can be drunk and still get meth

APPENDIX I

- We need additional agencies – employment agency. CanSask can really help
- There should be more communication between doctors, staff and clients; more listening to the clients regarding all their problems – more leeway with carries
- Brochures are too impersonal, conversation is a far better tool
- Should be more liberal with "carry policy" for people who are responsible with their methadone – it is not necessary to come to the clinic everyday
- There is a duplication of assessments – SASSI everywhere, can't you get it from the last place – it (SASSI) will tell if you are fooling
- Have to tell my story over and over, should be more communication
- For someone who has never used, can't tell me abstinence and AA are the only way, need to have been there
- Yes, need counsellors for things that you need, for guidance, learn to get back on your feet, able to get into University classes
- A person identifies their own problems, help them identify, offer help, talk about other issues (not just meth)
- Set up a group like AA – every group has triggers, it is how you deal with it – go to clinic for a one on one if you are triggered – meth is here to stay so there should be a group for them
- Counsellors should be educated, not ignorant (about drug use etc.) be accessible, provide information sessions for everybody (clients and other professionals – mayor, police, justice system)
- Addiction Counsellors should get to know the individual client, we are all different, have different needs
- Counsellors are needed as mediators – tell us what is available
- Tell us where to get help but we should do it ourselves, don't tell the other agency we are on meth because then they won't want us
- Outreach is needed
- Need counsellors, need a place to spill your guts, stigma in other places and you gotta talk
- AC decisions should carry more weight, not have to all go through the physicians
- Counsellors observe us and wait, need to stabilize, we don't want to talk at first, need help with emergency issues – don't want to be forced to talk, to go to meetings, want it to be available when ready to talk
- People don't really know what a counsellor can do
- Trust is a big issue, I'm still scared to be 100% honest, trust starts small and it grows
- First we need to know who you are, what you can do for an addict, give a list, feels safer being in a clinic
- I like home visits, get to know us and our families, it is a change to have a straight person come to my home
- We need some place to go – just for methadone people
- NA is judgmental because you are still on meth, good if you don't talk about meth
- NA/AA works if you don't talk about meth, but not when you are really in need and hurting

- Don't be too forceful, have realistic expectations – don't overwhelm people with goals and expectations
- Accept us where we are now, don't be down on us if we relapse
- Be careful, we are just starting to feel good and then a word or phrase just drops us
- Don't like- counsellors not listening, telling me what to do, not understanding feelings, counsellors giving the feeling that you can't be helped

Healthcare Information Sharing and Partnerships

- Counsellors should have lots of say with the doctor
- We need help in employment, education, family support, life skills, parenting, legal issues, transportation needed everyday
- Would like the clinic to be downtown, central, separate exit
- Lots of things happening in Europe, they are way ahead of us
- Government officials and more social workers should know about it (prescribed methadone), they become ignorant with you once they know you are on meth, think government is giving free dope
- Social worker doesn't believe I am drug free, tell her to check with the clinic, my urine checks are clean
- Social workers are constantly checking with police (this incident was regarding a protection social worker not understanding that the client could be on prescribed methadone and function as a parent), didn't know much about it
- Don't tell employers or teachers that a person is on meth, they get real leery
- Harm reduction – get educated - things are better now, there is a more open atmosphere
- Need more doctors – doctors need to learn, think you have pneumonia when you are dope sick

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